COMMENTARY

Breaking the Mold: Organizing Medical Care for New York City

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That disputes and confusion would accompany the Clinton Administration's proposal for "health reform" might have been guessed from the term alone. Neither health nor reform was implicit in the proposal, which aimed at readjusting the health insurance system to: include more of the population under the insurance umbrella; provide more and easier access to medical services for the insured; and check heretofore uncontrollable inflation of costs. But calling the process "health reform" was a doubtful message. Health is not a product of health insurance, but the outcome of a way of life. Health insurance is a way of paying for the costs of being diagnosed and treated for illness within what is called the "health-care system" (more accurately described as the medical care system). Insurance is a method of payment, but hardly a program for delivery of medical care services. The reform needed is the redesign of the medical care system.

For such reasons, the terminology employed ought to be "reorganization of the medical care system," or the "search for a national health program," rather than "health reform." If care of the sick were being discussed, whether or not insurance is the best way to finance such care could be argued; how the healers should be paid could be discussed, as well as who would take responsibility for the quality and satisfactory nature of the medical services to be provided, but the strategy for ensuring that all the sick people would be cared for must be the principal agenda item. The information could be brought out in public forums, in the media,

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in the legislatures; knowledgeable experts would be asked to provide the background information; and doctors and patients asked to speak to what makes for good medical care. Then an enlightened public, through its elected representatives, could decide on the design for payment for the defined system of care.

Be that as it may, in the event, everything conspired to frustrate the "health reform" effort. In the planning, the public was left ignorant of the deliberations, as if secret design would facilitate the presentation of a fully-formed and perfectly acceptable program. Physicians were largely excluded, as if their long-standing reluctance to systematic non-medical control justified the exclusion of patient care concepts from a health plan. On top of this, the Administration's putative allies, the insurance community, betrayed them. And the raucous Republicans, heedless of the depth of human distress and the perils of medical system bankruptcy, roiled the waters with hypocritical substitute plans and obstructive maneuvers.

Despite the failure of any measure aimed at health-care system reform in the 103rd Congress, problems of access, cost containment, and quality will remain salient and adjustment of the system to correct the defects will continue to be necessary. The likelihood of successor plans on the national scene as ambitious and socially committed is now remote. But there is a concerned public that will not let the matter simply disappear from the public agenda. Something related to extending medical care to those without insurance coverage will be sought. Something related to reducing costs and stemming inflation of costs will be tried.

At the same time, the 1994 election outcome makes it readily apparent that it will be in states and cities where the organizational changes in the health field will take place, and where the planning must be undertaken, not in Washington. This conforms closely to traditional developments; that is, the federalist principle that the states and local communities are the proper site for initiation of health and welfare mandates. In our time, because the federalist principle was superseded by twentieth-century events, state initiative is not easily handled. Yet in the face of federal failure to

cope with national medical care needs for almost a century, and in the light of the 1994 election returns, states and localities may very well be given the opportunity to experiment on methods of universal health coverage, medical care delivery design, cost containment, and the economic minutiae of fiscal policy in health matters.[1]

It is possible, and quite likely, that some states, agonizing over the disarray of medical care organization in their individual states, especially the relentless inflation of medical costs, will take steps to exercise control. Some already are doing so. But there are limits to how much a state can do; at present the federal government pays 40% of overall medical costs. Allowing prices and utilization to remain as it is, the inclusion of another 15% (the uninsured) will compel hated tax hikes. Moreover, there is a dangerous possibility that some projected intermediate steps may solve a piece of the problem only to create larger hazards and costs.

We are all in this together, except for the really wealthy, who can buy their way out no matter what happens. But a trillion dollars is now the cost of medical care and 90% of the population cannot supply that much without serious damage to their way of life and standard of living. A Spanish proverb reads, "Take what you want, says God, take it and pay for it." Doctors and patients, politicians of whatever stripe, and professionals need to discuss this with one another. What do we know of organization and administration, of raising money and paying it out, that can be applied to a reorganized medical care system that will allow physicians—healers—to make judgments based on their mutual consultation with their patients and to remove barriers to access and quality measures?

On the other hand, there are states that may be able to design statewide medical care systems, with federal help. It remains to be seen how well this is approached and carried out. Fifty experiments, with all the cacophony that would produce, is hardly useful. It would be better if the federal government would undertake a project, on the order of an experiment, to offer help and financial support to a few states as pilot programs, and, after a few years, to

evaluate the results. The best of what is learned in this fashion could be incorporated into a national program.

The argument can be made that eventually, states will undertake changes on their own, and the nation will reach the goal of a national program over time. Why not wait? Jeremy Bentham wrote as the first on his list of fallacies: "Wait a little, this is not the time."[2] Waiting will undermine the possibility of establishing standards by which states can guide themselves in innovation, and will make comparisons and evaluation impossible. We would have 50 different, uncoordinated efforts. One of the objectives of state initiative ought to be to learn from the good and bad experiences so that eventually a national program that covers the country in a unified way will come to pass. Orderly change is desirable.

In any event, the disastrous recent federal effort at development of a national health program, capping nearly a century of failures, underlines the wisdom of trying to develop a programmed state initiative. If states need to do some planning toward universal and comprehensive medical care systems on their own, what about urban centers that are, in their regional orbit, as large as or larger than many states? Would it not be helpful if an urban region like the New York City metropolitan area undertook that planning responsibility? New York City is larger than some states. Twenty years ago, New York City's planning agency and the New York Academy of Medicine commissioned a series of papers on revising medical care for New York City. One paper, "A Proposal for City Action in Dealing with Ambulatory Medical Care Under National Health Insurance," touched on or considered various alternatives for coordinating the fragmented, independently funded and uncooperative medical care institutions and programs. Essentially, however, it assumed a national payment scheme and recommended a prepaid ambulatory care network for the city (and region) based on a central payment agency. Other papers in that series are as appropriate today as they were then, and suggest what might be done in coordinating all medical services to promote universal access to health care in New York City.

Fifty years ago, the New York Academy of Medicine undertook

to examine "Medicine and the Changing Order", setting up a Committee with that name and commissioning a series of books that challenged America to consider the new social and professional obligations emerging in the science and practice of medicine after the massive changes incident to the Second World War.[4] Twelve volumes were published between 1945 and 1947, covering much of the professional areas, medical practice, medical education, dentistry, nursing, hospitals, public health, biomedical research, health insurance, and government. Much of the content went unnoted and unimplemented. The material was addressed chiefly to professionals in the field; the public and politicians were, if not ignored, hardly regarded as in the audience. Nevertheless, the comments by the Committee chairman on objectives resonates with our time, and the conclusions could not be more presciently applicable.

The Chairman of the Committee describes the project objectives (in 1946!):"To be informed on the nature, quality and direction of the economic and social changes that are taking place now and that are clearly forecast for the immediate future; to define in particular how these changes are likely to affect medicine in its various aspects; to determine how the best elements in the science of medicine and in its services to the public may be preserved and embodied in whatever new social order may ultimately develop.[4(pp.x-xi)]

The Report states, in conclusion, "All are agreed that medical service should eventually provide everything that science can offer toward the preservation of health and the cure of disease, and that it should make available these benefits to the entire population. There is agreement," the Report continues, "that medical service is not now optimally organized, supervised or distributed. . ." And it concludes, ". . .in a country as vast as ours no one plan can be applicable to all parts and that many and various experiments for extending and improving medical care in conformity with local conditions are urgently needed."[4(p.221)]

The temper of our times is such that there might be a more responsive audience, among professionals, politicians, and the

public. The plan advocated by the Clinton Administration energized our society; the defects and deficiencies of our crippled medical care system are now much more commonly recognized and understood. DeTocqueville noted, over a century ago, that those ills suffered with patience when remedies do not exist become intolerable when a cure is known.

The climate is different for many reasons. Not only are people intolerant of the vagaries of cost and coverage of insurance policies, and embarrassed by the thought of a wealthy country with millions of citizens unprotected against the costs of illness, the possibility of change is implicit in the fact that political action was taken, even if unsuccessfully. Something can be done! States are trying, federal government agencies are offering inducements for experimentation, physicians are waking to the fact that for decades they have yielded the high ground to economists and political scientists as leaders. Now is the time to recapture that lost leadership. The issue is people, not insurance policies; medical care, not insurance.

Should the New York Academy of Medicine sponsor a conference on the feasibility of redesigning New York metropolitan health services a coordinated effort? The aim would be to promote the New York metropolitan region as a comprehensive health care zone, universal coverage, coordinated ambulatory and hospital services, designs for maternal and child health coverage, and programs for the aging that combine social and medical factors. If undertaken, every aspect of the proposed operation should be explored, probably through a series of position papers in book form, as was done in the 1940s. The issues to be investigated should include the public-private sector dilemma, health insurance companies *versus* governmental supervision, the fate of public hospitals, physician reimbursement, prepaid group practices, public health agency responsibilities, and manpower usage and deployment. Models that exist in various parts of the country need to be described.

The nation needs health leadership, a push in the right direction. Can the Academy again play the role it did in the 1940s and

the 1970s to examine and redirect the focus of medical services toward care of the sick, toward medical care programs not only for the New York region, but for the nation?

References

1. See, for example, *National Health Reform: What Should the State Role Be?* Washington, DC: National Academy of Social Insurance, 1994.
2. Bentham J. *Handbook of Political Fallacies.* Baltimore, Maryland: Johns Hopkins University Press, 1952, p. 129.
3. Silver GA. *The Impact of National Health Insurance on New York.* Lieberman M, ed. New York: Prodist, 1977.
4. *Medicine in the Changing Social Order.* Report of the New York Academy of Medicine Committee on Medicine and the Changing Order. New York: Commonwealth Fund, 1947.